MEDICAL AID BENEFITS CANNOT RUN OUT

Prescribed Minimum Benefits

PMBs were introduced into the Medical Schemes Act to ensure that members of medical schemes would not run out of benefits for certain conditions and find themselves forced to go to state hospitals for treatment. These PMBs cover a wide range of close to 300 conditions, such as meningitis, various cancers, menopausal management, cardiac treatment and many others including medical emergencies.

Terminology

In order to understand the impact of the legislation changes, a clear understanding of the terminology is required:

Designated service provider (DSP)

This refers to health care provider/s that have been "selected by the scheme to provide its members diagnosis, treatment and care in respect of one or more of the PMB conditions".

Emergency medical condition

This is a medical condition which is of sudden and unexpected onset that requires immediate medical or surgical treatment. Failure to provide this treatment would result in impairment of bodily functions, serious dysfunction of a bodily organ or part, or would place the person's life in serious jeopardy.

Prescribed Minimum Benefits (PMB's)

PMB's are minimum benefits which by law must be provided to all medical scheme members and include the provision of diagnosis, treatment and care costs for:

- any emergency medical condition
- a range of conditions as specified in Annexure A of the Regulations to the Medical Schemes Act (No 131 of 1998), subject to limitations specified in Annexure A. Included in this list of conditions is the list of chronic conditions

Why have PMB's been legislated?

PMB's were introduced to avoid incidents where individuals lose their medical scheme cover in the event of serious illness and are put at serious financial risk due to unfunded utilization of medical services. They also aim to encourage improved efficiency in the allocation of private and public health care resources.

Why have 26 chronic illnesses been made PMBs?

By making these benefits mandatory, the government, on the Council for Medical Scheme's recommendation, hopes to stamp out attempts by schemes to rate members on the financial risk they pose to a scheme because of the state of their health. The Medical Schemes Act introduced the principle of community rating, whereby members of a scheme (or one of its options) pay the same rates for cover, regardless of their state of health. However, medical schemes have been making chronic benefits available only on options with higher contribution levels. In this way people with chronic conditions were effectively being risk-rated and forced to pay higher amounts for their cover.

Which 26 illnesses are covered?

1 Addison’s Disease
2 Asthma
3 Bi-polar Mood Disorder
4 Bronchiectasis
5 Cardiac Failure
6 Cardiomyopathy Disease
7 Chronic Renal Disease
8 Coronary Artery Disease
9 Crohn's Disease
10 Chronic Obstructive Pulmonary Disorder

11 Diabetes Insipidus
12 Diabetes Mellitus Type 1 & 2
13 Dysrhythmias
14 Epilepsy
15 Glaucoma
16 Haemophilia
17 HIV / AIDS
18 Hyperlipidaemia
19 Hypertension
20 Hypothyroidism
21 Multiple Sclerosis
22 Parkinson's Disease
23 Rheumatoid Arthritis
24 Schizophrenia
25 Systemic Lupus Erythematosis
26 Ulcerative Colitis

How did the Department of Health arrive at the list of chronic conditions?

Various factors were taken into account when identifying the diseases that would be covered, such as; the nature of the disease and how that disease would affect the quality of life of the individual; the most prevalent conditions; the affordability of the treatment and the financial impact to medical schemes.